

Today's Date: \_\_\_\_\_

Patient Name: \_\_\_\_\_ Sex: M  F

Date of Birth: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Email address: \_\_\_\_\_

Address: \_\_\_\_\_ Apt/Lot#: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip code : \_\_\_\_\_

Phone: \_\_\_\_\_  
HOME CELL WORK EMERGENCY # / CONTACT / RELATION TO PATIENT

Please list any person able to have access to your medical records:  N/A

Name \_\_\_\_\_ Relationship to Patient \_\_\_\_\_

Referring Physician: \_\_\_\_\_ Next Appointment: \_\_\_\_\_

**\*Complete this section ONLY if your treatment is the result of a WORK INJURY or AUTO ACCIDENT**

Do you have an attorney? Y  N  Employer name: \_\_\_\_\_ Occupation: \_\_\_\_\_

Is this visit due to a work injury or auto accident? Y  N  Accident / Injury Date: \_\_\_\_\_

**PAYMENT INFORMATION** (check and initial ONE of the following boxes)

- CASH PAYER / I DO NOT have insurance** and I will pay out of pocket with cash, check, or credit card for services. A \$35.00 fee will be charged to my account for returned checks and may result in RPC asking for a different form of payment. I will speak with staff about payment options available.
- INSURANCE / I HAVE insurance** and want RPC to file all claims for services. I will assign all benefits to RPC and I understand I am responsible for my deductible, co-payment &/or coinsurance associated with my insurance plan for each date of service. I understand that I am financially responsible for any non-covered service(s). It is my responsibility to know my insurance policy and to notify this practice of any changes to my policy and/or coverage.

**Primary Insurance:** \_\_\_\_\_ Are you the primary policy holder? Y  N

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

**Secondary Insurance:** \_\_\_\_\_ Are you the primary policy holder? Y  N

Policy#: \_\_\_\_\_ Group#: \_\_\_\_\_

Have you had PT this year? Y  N  If yes, where \_\_\_\_\_

Do you live in a Nursing Home? Y  N  If yes, where \_\_\_\_\_

Are you covered under Black Lung Disease? Y  N  Do you receive Home Health Services? Y  N

Are you covered under End Stage Renal Disease? Y  N

**We LOVE our referrals! How did you hear about us?**  Newspaper/column  Online Search  Family  Friend  
 Doctor  Other \_\_\_\_\_

We strive to provide you the best-personalized experience - to make this possible; we adhere to a set of very important guidelines. **Read carefully. Ask questions. Sign and date the bottom.**

**CONSENT TO TREAT** I allow Lake Oconee Rehabilitation and Performance Center, LLC (RPC) to perform rehabilitation treatment. I have the right to ask about risks and have questions answered about my condition prior to treatment. I understand I will have the opportunity to discuss my condition with the treating physical therapist and that I should notify RPC of any changes to my condition that could affect my response to therapy.

**FINANCIAL POLICIES** Insurance coverage is a contract between the insurance carrier and me. If my insurance company does not remit payment within **60 days**, I will be responsible for the amount due in full. Returned checks are subject to a \$35.00 returned check fee and balances older than 30 days may be subject to additional fees and interest charges of 2 percent per month and I will be responsible for any charges incurred due to collection proceedings, attorney fees or court cost. I certify that the information I have provided to RPC for payment including, but not limited to, related accidents, illnesses or other insurers is accurate and truthful. I understand and authorize RPC to maintain and use a payment on file (such as a credit or debit card) for charges that are my responsibility and authorize RPC to use the card for such charges. I further understand that receipts will be issued electronically unless otherwise specified to RPC.

**ASSIGNMENT OF BENEFITS** I authorize direct payment of medical benefits from my insurance carrier(s) to RPC for services delivered. I agree to promptly pay RPC monies paid directly to me for said services. I authorize the release of any medical information relating to all claims for benefits submitted on behalf of myself and/or dependents.

**CO-PAYS, DEDUCTIBLES, CO-INSURANCE** I understand that all payments designated as "the patient's responsibility" and / or "not covered" such as deductibles, co-insurance, and co-payments are due at the time of service and are my financial responsibility.

**NOTICE FROM FEDERAL GOVERNMENT** *It is unlawful to routinely waive co-payments, deductibles, coinsurances or other patient responsibility payments."* (67 Fed. Reg. 72,896 (Dec. 9, 2002))

**REQUEST FOR ELECTRONIC ACCESS / EMAIL COMMUNICATION AUTHORIZATION** I authorize RPC to contact me by telephone and/or email. RPC uses telephone and/or email for communication such as claim payment assistance, appointment reminders &/or setting up an account portal. I understand that anyone with access to my telephone/voicemail/email can retrieve/view this information if my not secured and thus, will not be protected by federal or state laws. This will remain in force until written termination is received by LORPC at 117 Harmony Crossing, Suite 4, Eatonton, GA 31024 / Attn: Practice Manager. Treatment is not based on signing this authorization.

**FINANCIAL HARDSHIP** If I am experiencing financial difficulties and am unable to afford the cost of physical therapy services I can complete a 'Financial Hardship' request before services are provided. Completing the request form is not a guarantee of assistance or release of financial responsibility. Approval is based on financial need. See staff for assistance.

**LATE ARRIVALS / CANCELLATION / NO SHOW POLICIES** I have received a copy of this policy and understand that if incurred, these charges are my responsibility and will not be billed to my insurance.

**PRIVACY NOTICE / PATIENT RIGHTS / HIPAA ACKNOWLEDGEMENT** I have received a copy of RPC's Notice of Privacy Practices, HIPAA, and PHI disclosure and use.

**Your signature acknowledges receipt, acceptance, and your understanding of the above information.**

(PRINT) PATIENT NAME

Patient / Responsible Party Signature

Date

### PATIENT INFORMATION FORM

Legal Name: \_\_\_\_\_ Gender: M F Age: \_\_\_\_\_

Leisure Activities: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Referring Doctor: \_\_\_\_\_ Returning appointment date: \_\_\_\_\_

Currently seen by:  Medical Doctor  Psychiatrist/Psychologist  Dentist  Physical Therapist  Chiropractor  Osteopath

Onset of current injury/symptoms (date) \_\_\_\_\_

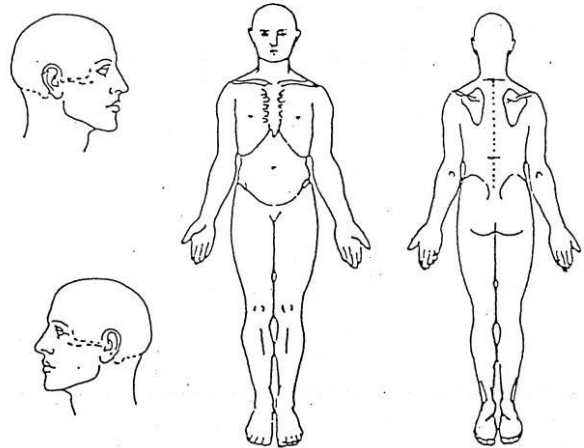
Have you had surgery as a result of your current injury?  Yes  No If yes, date of surgery: \_\_\_\_\_

Have you had physical therapy for the current injury/symptoms?  Yes  No

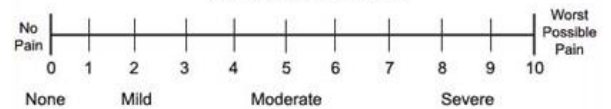
Describe current injury / symptoms: \_\_\_\_\_

Allergies	Yes	No	Gallbladder Problems	Yes	No
Anemia	Yes	No	Hepatitis	Yes	No
Anxiety	Yes	No	High Blood Pressure	Yes	No
Arthritis	Yes	No	Incontinence	Yes	No
Asthma	Yes	No	Kidney Problems	Yes	No
Cancer	Yes	No	Metal Implants	Yes	No
Cardiac Conditions	Yes	No	Multiple Sclerosis	Yes	No
Cardiac Pacemaker	Yes	No	Osteoporosis	Yes	No
Chemical Dependency	Yes	No	Parkinson's	Yes	No
Circulation Problems	Yes	No	Rheumatoid Arthritis	Yes	No
Currently Pregnant	Yes	No	Seizures	Yes	No
Depression	Yes	No	Speech Problems	Yes	No
Diabetes	Yes	No	Strokes	Yes	No
Dizzy Spells	Yes	No	Thyroid Disease	Yes	No
Emphysema/Bronchitis	Yes	No	Tuberculosis	Yes	No
Fractures	Yes	No	Vision Problems	Yes	No
Falls	Yes	No			
2 or more Falls in past year	Yes	No			

Please circle the locations of your pain



Pain Rating Scale<sup>©</sup> Mosby



Other conditions the physical therapist should know about that are not listed above? If yes, please provide:


Patient Legal Name: \_\_\_\_\_ Date: \_\_\_\_\_

Allergies:  None List allergies here: \_\_\_\_\_  
\_\_\_\_\_

**CURRENT PRESCRIBED MEDICATIONS:**

Medication Name	Reason taken	Dose	Frequency	Route

**SURGICAL HISTORY**

Body Region	Surgery Type	Date / Year of surgery

**Your signature acknowledges that all information given is accurate and truthful to the best of your knowledge.**

\_\_\_\_\_  
Patient / Responsible Party Signature Date

## PRIVACY NOTICE / PATIENT RIGHTS

EFF 09/2013 / BOM 140/R 062016

This notice is to advise you of how your Protected Health Information (PHI) may be used and disclosed. Rehabilitation and Performance Center, LLC is committed to keeping your health information secure. We are legally obligated to give you this notice. Please review this information carefully.

### Our Uses and Disclosures

- The law permits us to disclose information to those involved in your treatment
- Run our organization
- We may disclose information for billing purposes, seeking insurance or health benefits information, insurance authorization and payment services
- Help with public health and safety issues
- We may use your information to contact you, to remind you of your appointments, for scheduling purposes, leaving messages on a machine or with a person, or to inform you of insurance benefit.
- We will release some or all of your information when requested by law, which includes but not limited to lawsuits / legal actions.
- Address workers' compensation, law enforcement, and other government requests
- Your authorization is required to disclose your health information to other healthcare providers, individuals, or third parties requesting information about you.

### You have the Responsibility to:

- Give complete, and accurate and timely medical, personal demographic and payer information to this facility
- Comply with the plan of care to the best of your ability which includes but is not limited to, following home program/instruction, punctually attending scheduled sessions and adhering to known limitations and precautions.
- Advise the therapist when rehabilitative goals or treatment approach requires modification secondary to external complicating factors including but not limited to physical or mental health, family, work or religious conflicts or commitments.
- Adhere to obvious department guidelines while at the facility including but not limited to, courteous interaction with staff, other patients/clients/visitors, conscientious personal hygiene and modesty and respect for treatment and clinical record confidentiality for self and others.
- Provide objective complaint notification to the Owner or designated staff as well as the state Licensing Boards and/or other regulatory agencies if indicated.

### Individual Rights – *You have the Right to:*

- Request a paper / electronic copy of this notice and/or a copy of your medical records at any time.
- Submit a written request to amend incorrect data. Note that an addendum will be added to the record if agreed to amend.
- An accounting of all disclosures and request confidential communications.
- Opt-out of marketing and fundraising efforts. We will not sell personal information without your written permission.
- Restrict certain disclosures of PHI including the right to limit disclosures of information to Medicare or any other payer related to services the individual(s) have paid for out of pocket.
- Choose someone to act for you.
- File a complaint with us, without fear of penalty, if you believe your privacy rights have been violated.

If you believe that your rights have been violated you may also contact:

**Department of Health and Human Services**  
200 Independence Ave. SW, RM 509F  
Washington, DC 20201  
1-877-696-6775 or visit on the  
[www.hhs.gov/ocr/privacy/hipaa/complaints/](http://www.hhs.gov/ocr/privacy/hipaa/complaints/)

You will not be penalized for filing a complaint. Before filing a complaint, we request you ask for assistance regarding the privacy of your healthcare information by contacting Lake Oconee Rehabilitation and Performance Center, LLC at 706-454-1811 or 706-395-3628.

**Breach Notification:** If PHI is breached, either through a covered entity or a covered business associate, updated rules establish mandatory reporting to include the affected individual(s), the Secretary of the US, Department of Health and Human Services, and in some cases the media when covering a breach of unsecured PHI.

A full copy of our Privacy Notice is available upon request.

## LATE ARRIVALS, CANCELLATION, & NO SHOW POLICIES

**We want all our patients to receive the maximum possible benefit from physical therapy – this can only happen if you attend the appointments**

Our schedules fill up quickly, and for you to receive the best outcome, it is important for your recovery to be on time and to keep the scheduled appointments. While we do our best, if an appointment is cancelled or missed, RPC offers no guarantee that an appointment can be rescheduled at a time or date requested.

### LATE ARRIVALS

We ask all patients to be respectful of our schedules and other patients by arriving on time for all scheduled appointments. If you are more than 15 minutes late, your appointment may need to be rescheduled. Multiple rescheduling of appointments can result in a rescheduling fee of **\$25.00**. Being late to your appointment affects your recovery, the therapist, other patient's treatment, and can result in additional charges to you. Please be on time.

### CANCELLATION POLICY

RPC requests at least a 24 hour notice to cancel an appointment. Providing this notice gives our staff time to offer services to another patient who may be waiting for an appointment. Voice mails/messages left after hours are acceptable notifications as they are time and date stamped for verification purposes.

**If a 24 hour notice is not provided, a \$55.00 charge will be added to your account**

### NO SHOW POLICY

**A \$55.00 charge will be added to your account for all missed appointments**

### NOTICE TO PATIENTS

I understand that as with all businesses, it is imperative that I attend my appointments to receive maximum benefit of physical therapy and additionally, I understand and agree to pay any charges associated with any rescheduled, missed, or cancelled appointments. ***Any charges due to rescheduling, cancellation(s), or no shows must be paid prior to my next scheduled appointment.***

I understand that insurance will not be billed for these charges if incurred and that these charges are solely the responsibility of the patient. I understand if I have three or more missed appointments or multiple cancellations, any additional appointments may be removed from the schedule and a possible discharge from therapy services may result.